

Health Care for Veterans: Answers to Frequently Asked Questions

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Summary

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates the nation's largest integrated health care delivery system, provides care to approximately 5.75 million unique veteran patients, and employs more than 270,000 full-time equivalent employees.

Eligibility and Enrollment. Contrary to claims concerning promises of “free health care for life,” not every veteran is automatically entitled to medical care from the VA. Eligibility for VA health care is based primarily on veteran status resulting from military service. Generally, veterans must also meet minimum service requirements; however, exceptions are made for veterans discharged due to service-connected disabilities, members of the Reserve and National Guard (under certain circumstances), and returning combat veterans. The VA categorizes veterans into eight Priority Groups, based on factors such as service-connected disabilities and income (among others). Dependents, caregivers, and survivors of certain veterans are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), which reimburses non-VA providers or facilities for their medical care.

Medical Benefits. All enrolled veterans are offered a standard medical benefits package, which includes (but is not limited to) inpatient and outpatient medical services, pharmaceuticals, durable medical equipment, and prosthetic devices.

For female veterans, the VA provides gender-specific care, such as gynecological care, breast and reproductive oncology, infertility treatment, maternity care, and care for conditions related to military sexual trauma. Under current regulations, the VA is not authorized to provide, or cover the costs of, in vitro fertilization, abortion counseling, abortions, or medication to induce abortions.

Generally the VA provides audiology and eye care services (including preventive services and routine vision testing) for all enrolled veterans, but eyeglasses and hearing aids are provided only to veterans meeting certain criteria. Eligibility for VA dental care is limited and differs significantly from eligibility for medical care. For veterans with service-connected disabilities who meet certain criteria, the VA provides short- and long-term nursing care, respite, and end-of-life care.

Under certain circumstances, the VA may reimburse non-VA providers for health care services rendered to VA-enrolled veterans on a fee-for-service basis. Such Fee Basis Care may include outpatient care, inpatient care, emergency care, medical transportation, and dental services.

Costs to Veterans and Insurance Collections. While enrolled veterans do not pay premiums for VA care, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of nonservice-connected conditions. Copayment amounts vary by Priority Group and type of service (e.g., inpatient versus outpatient). The VA has the authority to bill most health care insurers for nonservice-connected care; any insurer's payment received by the VA is used to offset “dollar for dollar” a veteran's VA copayment responsibility. The VA is statutorily prohibited from receiving Medicare payments (with a narrow exception).

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Introduction

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates the nation's largest integrated direct health care delivery system, provides care to approximately 6.6 million unique veteran patients,¹ and employs more than 287,000 full-time equivalent employees.² While Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are also publicly funded programs, most health care services under these programs are delivered by private providers in private facilities. In contrast, the VA health care system could be categorized as a veteran-specific national health care system, in the sense that the federal government owns the medical facilities, employs the health care providers, and directly provides the majority of health care services to veterans.³

It should be noted that **VA health care is *not* a health insurance plan** similar to what many individuals or employers purchase in the private health insurance market and does not have the same health insurance plan characteristics, such as coinsurances,⁴ deductibles,⁵ and premiums.⁶

This report provides responses to frequently asked questions about health care provided to veterans through the VHA. It is intended to serve as a quick reference to provide easy access to information. Where applicable, it provides the legislative background pertaining to the question.

Enrollment in VA Health Care

Can All Veterans Enroll in VA Health Care?

*Not every veteran is automatically eligible to enroll in VA health care, contrary to numerous claims made concerning "promises" to military personnel and veterans with regard to "free health care for life."*⁷

Eligibility for enrollment in VA health care has evolved over time. Prior to eligibility reform in 1996, all veterans were technically eligible for some care; however, the actual provision of care was based on available resources.⁸

¹ CRS Report R43547, *Veterans' Medical Care: FY2015 Appropriations*, by Sidath Viranga Panangala.

² Department of Veterans Affairs, *FY2016 Budget Submission, Budget In Brief* February 2015, p10.

³ Adam Oliver, "The Veterans Health Administration: An American Success Story?" *The Milbank Quarterly*, vol. 85, no. 1 (March 2007), pp. 5-35.

⁴ A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

⁵ A fixed dollar amount during the benefit period—usually a year—that an insured person pays before the insurer starts to make payments for covered medical services.

⁶ A person enrolled in a private health insurance plan must pay a fee (premium), typically on a monthly basis, to maintain coverage under the plan. For more information on health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez and Namrata K. Uberoi.

⁷ For a detailed discussion of "promised benefits," see CRS Report 98-1006, *Military Health Care: The Issue of "Promised" Benefits*, by David F. Burrelli.

⁸ Barbara Sydel, "Restructuring the VA Health Care System: Safety Net, Training and Other Considerations," National (continued...)

The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) established two eligibility categories and required VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.⁹ (See the **Appendix** for the criteria for the Priority Groups.) P.L. 104-262 authorized the VA to provide all needed hospital care and medical services to veterans with service-connected disabilities;¹⁰ former prisoners of war; veterans exposed to toxic substances and environmental hazards such as Agent Orange; veterans whose attributable income and net worth are not greater than an established "means test"; and veterans of World War I. These veterans are generally known as "higher priority" or "core" veterans.¹¹ The other category of veterans are those with no service-connected disabilities and with attributable incomes above an established "means test."

P.L. 104-262 also authorized the VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L. 104-262,

[t]he Act would direct the Secretary, in providing for the care of 'core' veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.¹²

Furthermore, P.L. 104-262 was clear in its intent that the provision of health care to veterans was dependent upon available resources. The committee report accompanying P.L. 104-262 states that the provision of hospital care and medical services would be provided to "the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations."¹³

Which Veterans Can Enroll in VA Health Care?

Enrollment in VA health care is based primarily on veteran status (i.e., previous military service), service-connected disability,¹⁴ and income.¹⁵

Generally, veteran status is established by (1) active duty service in the military, naval, or air service; (2) satisfying a minimum period of duty;¹⁶ and (3) receiving an other than dishonorable

(...continued)

Health Policy Forum, Issue Brief no. 716, March 1998.

⁹ U.S. Congress, House Committee on Veterans Affairs, *Veterans' Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong. 2nd sess., H.Rept. 104-690, p. 2.

¹⁰ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

¹¹ H.Rept. 104-690, p. 5.

¹² Ibid., p. 6.

¹³ Ibid., p. 5.

¹⁴ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

¹⁵ Veterans meeting certain income criteria may be eligible to enroll in the VA without a service-connected condition.

discharge or release.¹⁷ Exact requirements for enrollment eligibility depend on various criteria, such as when and in which component (i.e., active, Reserves, or National Guard) the veteran served. See below for questions and answers about returning combat veterans and members of the Reserves and National Guard.

Is Enrollment Different for Returning Combat Veterans?

Veterans returning from combat operations are eligible to enroll in VA health care for five years from the date of their most recent discharge without having to demonstrate a service-connected disability or satisfy an income requirement. Veterans who enroll under this extended enrollment authority continue to be enrolled even after the five-year eligibility period ends.

This special period of enrollment eligibility for VA health care was first established in 1998 and was expanded in 2007. In 1998, Congress, responding to the growing concerns of Persian Gulf War veterans' undiagnosed illnesses, passed the Veterans Programs Enhancement Act of 1998 (P.L. 105-368), entitling a veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War to be eligible to enroll in VA health care during a two-year period following the date of discharge.

In 2007, the National Defense Authorization Act (NDAA), FY2008 (P.L. 110-181) extended the period of enrollment eligibility for VA health care from two to five years for veterans who served in a theater of combat operations after November 11, 1998.¹⁸ If returning veterans do not enroll during this five-year enrollment window (from the date of discharge), future applications for enrollment will be evaluated according to the Priority Group classifications described in the **Appendix**. For this reason, the VA encourages veterans to take advantage of the enhanced enrollment period. The Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2) authorized an additional one-year period of eligibility to enroll for those veterans who were discharged from active duty after January 1, 2009, and before January 1, 2011, but did not enroll during the five-year period of post discharge eligibility. This one-year period began on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act (February 12, 2015).

(...continued)

¹⁶ Generally, persons enlisting in one of the Armed Forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. For more information about how duty periods are defined, see U.S. Department of Veterans Affairs, "Duty Periods for Establishing Eligibility for Health Care," 78 *Federal Register* 78260, December 26, 2013.

¹⁷ A veteran with an "other than honorable" discharge or "bad conduct" discharge may still retain eligibility for VA health care benefits for disabilities incurred or aggravated during service in the military. For more information on the nature of discharge requirements, see CRS Report R42324, *Who is a "Veteran"?—Basic Eligibility for Veterans' Benefits*, by Umar Moulta-Ali.

¹⁸ For those servicemembers who are called to duty multiple times, this will be the most recent discharge date. Generally, returning combat veterans are assigned to Priority Group 6, unless eligible for a higher Priority Group, and are not charged copays for medication and/or treatment of conditions that are potentially related to their combat service. At the end of the five-year period, veterans enrolled in Priority Group 6 may be re-enrolled in Priority Group 7 or 8, depending on their service-connected disability status and income level, and may be required to make copayments for nonservice-connected conditions. The above criteria apply to National Guard and Reserve personnel who were called to active duty by federal executive order and served in a theater of combat operations after November 11, 1998.

Is Enrollment Different for Members of the Reserves?

When not activated to full-time federal service, members of the Reserve components have limited eligibility for VA health care services.

Similar to regular active duty servicemembers, members of the Reserve components may be eligible for enrollment for VA health care based on veteran status (i.e., previous military service), service-connected disability,¹⁹ and income.

Reservists achieve veteran status and are exempt from the 24-month minimum duty requirement (as described above) if they (1) were called to active duty, (2) completed the term for which they were called, and (3) were granted an other-than-dishonorable discharge.

Members of the Reserve components may be granted service-connection for any injury they incurred or aggravated in the line of duty while attending inactive duty training assemblies, annual training, active duty for training, or while going directly to or returning directly from such duty. In addition, Reserve component servicemembers may be granted service-connection for a heart attack or stroke if such an event occurs during these same periods. The granting of service-connection makes them eligible to receive care from the VA for those conditions.

Is Enrollment Different for Members of the National Guard?

When not activated to full-time federal service, members of the National Guard have limited eligibility for VA health care services.

Similar to regular active duty servicemembers, members of the National Guard may be eligible for enrollment in VA health care based on veteran status (i.e., previous military service), service-connected disability,²⁰ and income.

National Guard members achieve veteran status and are exempt from the 24-month minimum duty requirement (as described above) if they (1) were called to active duty by federal executive order, (2) completed the term for which they were called, and (3) were granted an other than dishonorable discharge.

National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.²¹

¹⁹ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

²⁰ A service-connected disability is a disability that was incurred or aggravated in the line of duty in the U.S. Armed Forces (38 U.S.C. §101 (16)). The VA determines whether veterans have service-connected disabilities, and for those with such disabilities, assigns ratings from 0% to 100% based on the severity of the disability. Percentages are assigned in increments of 10% (38 C.F.R. §§4.1-4.31).

²¹ 38 U.S.C. §101(24); 38 C.F.R. §3.6(c).

How Do Veterans Enroll in VA Health Care?

To receive VA health care, most veterans must enroll by completing and submitting the VA's Application for Health Benefits (VA Form 10-10EZ).²²

The following eight-step VA health care enrollment process is illustrated in **Figure 1**:

1. A veteran may apply for enrollment at any time of year by submitting the application for enrollment (online, in person, by mail, or by fax) to a VA health care facility. The application form includes information about the veteran's military service, demographics, and (as applicable) financial status.
2. Upon receipt of the enrollment application, the VA health care facility enters the information into the Veterans Health Information Systems and Technology Architecture (VistA) system, which creates an electronic record for the veteran. (If the enrollment application is submitted in person, a preliminary eligibility determination is typically provided at the time of application.)
3. The VistA system transmits the veteran's application information to the VA's centralized Eligibility and Enrollment System.
4. The VA's centralized Eligibility and Enrollment System establishes the veteran's record and queries the Veterans Benefits Administration (VBA) records.
5. The VBA returns information about the veteran's military status and/or compensation and pension benefits.
6. The VA's centralized Eligibility and Enrollment System verifies the veteran's enrollment eligibility and shares these data with VistA. (If the enrollment system is unable to determine eligibility, it alerts the veteran's local VA medical center to take further action.)
7. When a determination has been made, the VA's centralized Eligibility and Enrollment System sends the veteran a letter with that information.
8. The veteran receives the letter from the VA.

The VA developed this enrollment process pursuant to the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262), which required the establishment of a national enrollment system to manage the delivery of veterans' inpatient and outpatient medical care. Congress created the new eligibility standard to "ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished."²³

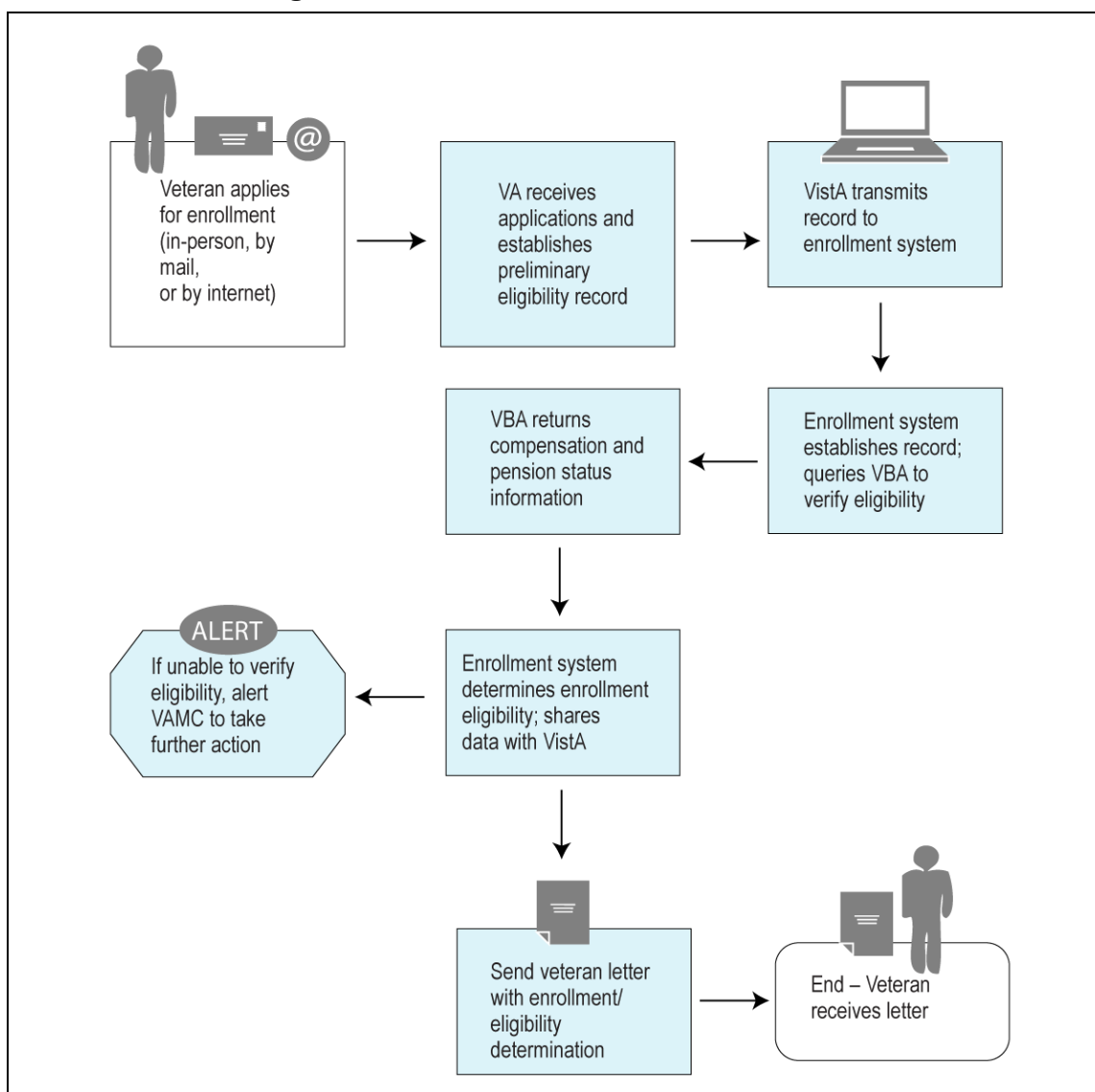
²² VA Form 10-10EZ is available at <https://www.1010ez.med.va.gov/sec/vha/1010ez/>. Veterans do not need to apply for enrollment in the VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated at 50% or more (percentages of disability are based upon the severity of the disability, and those with a rating of 50% or more are placed in Priority Group 1); veterans for whom less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%).

²³ H.Rept. 104-690, p. 4.

The VA classifies veterans into eight enrollment Priority Groups based on an array of factors, including (but not limited to) service-connected disabilities or exposures,²⁴ prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income. (The criteria for each Priority Group are summarized in the **Appendix**.) Once a veteran is enrolled in the VA health care system, the veteran remains in the system and does not have to reapply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 based on income are generally reevaluated annually with updated financial information. The VA receives income information from the Internal Revenue Service (IRS) and the Social Security Administration (SSA). If this information changes, the veteran may be asked to provide updated financial information; however, any veteran may submit information at any time using VA Form 10–10EZ (e.g., if he or she believes it will affect his or her enrollment status).²⁵

²⁴ For example, veterans who may have been exposed to Agent Orange during the Vietnam War or veterans who may have diseases potentially related to service in the Gulf War may be eligible to receive care.

²⁵ U.S. Department of Veterans Affairs, “Discontinuance of Annual Financial Assessments,” 78 *Federal Register* 64066, October 25, 2013.

Figure 1.VA Health Care Enrollment Process

Source: Institute of Medicine, *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*, 2010, p. 124, adapted by Congressional Research Service.

Notes: VistA = Veterans Health Information Systems and Technology Architecture; VBA = Veterans Benefits Administration; VAMC = VA Medical Center.

Are Veterans' Family Members Eligible for VA Health Care?

Veterans' family members are not eligible for enrollment in VA health care services. However, certain dependents and survivors may receive reimbursement from the VA for some medical expenses.

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) pays for health care services to dependents and survivors of certain veterans. It is primarily a fee-for-service program that provides reimbursement for most medical care that is provided by non-VA providers or facilities. On May 5, 2010, President Barack Obama signed into law the

Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163), which expanded the CHAMPVA program to include the primary family caregiver of an eligible veteran who has no other form of health insurance, including Medicare and Medicaid.²⁶ Health care services provided include counseling, training, and mental health services for the primary family caregiver. For more information, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala.

Medical Benefits

What Are the Standard Medical Benefits?

The VA offers all enrolled veterans a standard medical benefits package that includes (among other things) inpatient care, outpatient care, and prescription drugs.

The VA's standard medical benefits package includes a broad spectrum of inpatient, outpatient, and preventive medical services, such as the following:

- medical, surgical, and mental health care, including care for substance abuse;
- prescription drugs, including over-the-counter drugs, and medical and surgical supplies available under the VA national formulary system;
- durable medical equipment and prosthetic and orthotic devices, including hearing aids and eyeglasses (subject to limitations);²⁷
- home health services, hospice care, palliative care, and institutional respite care;
- noninstitutional adult day health care and noninstitutional respite care;
- periodic medical exams, among other services;²⁸ and
- complementary and alternative medicine (CAM) therapies.²⁹

The medical benefits package does not include the following:

- abortions and abortion counseling;
- in vitro fertilization;

²⁶ For more information on the VA family caregiver program, see http://www.caregiver.va.gov/support_benefits.asp.

²⁷ Hearing aids and eyeglasses are part of the standard medical package for veterans meeting either of the following criteria: (1) any veteran with a service-connected condition rated 50% or more on one or more disabilities or based on Individual Unemployability or (2) veterans needing care for a service-connected condition.

²⁸ A detailed listing of the VHA's standard medical benefits package is available at 38 C.F.R. §17.38.

²⁹ Complementary and alternative medicine (CAM) refers to treatments not considered to be standard in the current practice of Western medicine, such as acupuncture, massage therapy, and yoga, among others. Although not part of the standard medical package, according to the VA, approximately 89% of VA facilities offer at least one form of CAM, and these therapies are integrated into traditional VA care. For more information on CAM, see Department of Veterans Affairs, War Related Illness and Injury Study Center, "Complementary and Integrative Medicine: A Resource for Veterans, Service Members, and Their Families," fact sheet, <http://www.warrelatedillness.va.gov/education/factsheets/complementary-and-integrative-medicine.pdf>.

- drugs, biologicals, and medical devices not approved by the Food and Drug Administration (FDA), unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption;
- gender alterations;
- hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give such care or services; and
- membership in spas and health clubs.³⁰

Does the VA Provide Gender-Specific Services for Women?

The VA's standard medical benefits package addresses the health care needs of enrolled female veterans by providing (directly or through access to non-VA providers) gynecological care, maternity care, infertility, breast and reproductive oncology, and care for conditions related to military sexual trauma (MST), among other services.

In addition, the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorized the VA to provide certain health care services to a newborn child of a female veteran receiving maternity care furnished by the VA. Health care for the newborn will be authorized for a maximum of seven days after the birth of the child if the veteran delivered the child in a VA facility or in another facility pursuant to a VA contract for maternity services.

Under current regulations, the VA is not authorized to provide or cover the cost of in vitro fertilization (IVF), abortions, abortion counseling, or medication to induce an abortion (e.g., mifepristone, also known as RU-486).³¹

Does the VA Provide Dental Care?

Eligibility for dental care is extremely limited, and differs significantly from eligibility requirements for medical care.

For VA dental care eligibility, enrolled veterans are categorized into classes, which form the basis for the scope of dental treatment provided. **Table 1** describes the eligibility criteria and scope of treatment for VA-provided dental care.

³⁰ 38 C.F.R. §17.38.

³¹ 38 C.F.R. §17.38; and Department of Veterans Affairs, Veterans Health Administration, *Health Care Services for Women Veterans*, VHA Handbook 1330.01, May 21, 2010.

Table I. Eligibility Criteria and Scope of Treatment for VA Dental Care

Classification	Eligibility Criteria	Scope of Treatment Provided
Class I	Veteran has a service-connected compensable (disability compensation paid) dental condition	Any necessary dental treatment to maintain or restore oral health and masticatory function, including repeat care
Class II	Veteran has a service-connected noncompensable dental condition (not subject to disability compensation) shown to have been in existence at the time of discharge or release from active duty service, which took place after September 30, 1981, if: The veteran served at least 180 days (or 90 days if a veteran of the Gulf War era), and The veteran's DD214^a does not bear certification that the veteran was provided, within 90 days immediately prior to discharge or release, a complete dental examination (including dental x-rays) and all appropriate dental treatment indicated by the examination to be needed, and Application for treatment is received within 180 days of discharge	A one-time course of dental treatment of the service-connected noncompensable dental condition
Class II (a)	Veteran has a service-connected noncompensable dental condition or disability determined as resulting from combat wounds or service trauma	Any necessary dental treatment for the correction of the service-connected condition. Generally, a Dental Trauma Rating or VA Regional Office Rating Decision letter identifies the tooth/teeth eligible for care.
Class II(b)	Veteran is homeless or are otherwise enrolled in certain VA-sponsored rehabilitation programs	A one-time course of dental treatment
Class II(c)	Veteran is a former prisoner of war (POW)	Any necessary dental treatment to maintain or restore oral health and masticatory function, including repeat care
Class III	Veteran has a nonservice-connected dental disability professionally determined to be aggravating a service-connected medical condition	A one-time course of dental treatment to treat only the oral condition that is directly impacting the management of the service-connected medical condition. Eligibility for each new course of dental treatment is a based on a new dental evaluation.
Class IV	Veteran whose service-connected disabilities have been rated at 100% or who is receiving the 100% rating by reason of individual unemployability.	Any necessary dental treatment to maintain or restore oral health and masticatory function, including repeat care

Classification	Eligibility Criteria	Scope of Treatment Provided
Class V	Veteran who is approved for VA vocational rehabilitation training and who requires dental treatment to participate in the training	Dental care to the extent needed to meet any of the following goals: 1. make possible his or her entrance into a rehabilitation program; 2. achieve the goals of the veteran's vocational rehabilitation program; 3. prevent interruption of a rehabilitation program; 4. hasten the return to a rehabilitation program of a veteran in interrupted or leave status; 5. hasten the return to a rehabilitation program of a veteran placed in discontinued status because of a dental condition; 6. secure and adjust to employment during the period of employment assistance; or 7. enable the veteran to achieve maximum independence in daily living
Class VI	Veteran scheduled for admission to VA medical center or otherwise receiving care and services, if dental care is reasonably necessary to the provision of such care and services, that is, a dental condition is complicating a medical condition currently under treatment. (Examples: patients scheduled for cardiac surgery, knee, hip, joint replacement surgery, or organ transplant surgery may receive pre-bed care to eliminate dental infection prior to their surgery to help insure successful medical treatment)	A one-time course of dental treatment to treat conditions that directly impact the management of the nonservice-connected medical condition

Source: 38 C.F.R. §§17.160-162 and Department of Veterans Affairs, Veterans Health Administration, *Criteria and Standards for Dental Program*, VHA Handbook 1130.01, December 25, 2008.

Notes:

- When servicemembers separate from active military service, they each receive a certificate of release or discharge from active duty, known as a DD-214. The DD-214 provides the member and the service with a concise record of a period of service with the Armed Forces at the time of the member's separation, discharge, or change in military status (reserve/active duty). In addition, the form serves as an authoritative source of information for both governmental agencies and the Armed Forces for purposes of employment, benefit, and reenlistment eligibility, respectively.

What Is the VA Dental Insurance Program for Veterans and Survivors and Dependents of Veterans (VADIP)?

The VA Dental Insurance Program (VADIP) is a pilot program that provides premium-based dental insurance coverage through which eligible individuals may choose to obtain dental insurance from a participating insurer.³²

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) authorized the VHA to conduct a three-year pilot program to assess the feasibility and advisability of providing private, premium-based dental insurance coverage to eligible veterans and certain survivors and dependents.³³ Generally, survivors and dependents that would qualify for the program will be Civilian Health and Medical Program of the VA (CHAMPVA) beneficiaries. Under the three-year pilot program (set to expire in August 2016), the VHA contracted with qualified dental insurance carriers that provide dental insurance and administer all aspects of the dental insurance plan. The VHA administers the contract with the private insurer and verifies eligibility of veterans, survivors, and dependents.³⁴

Does the VA Provide Hearing Aids and Eyeglasses?

Generally, the VA provides audiology and eye care services (including preventive care services and routine vision testing) for all enrolled veterans. The VA does not provide hearing aids or eye glasses for normally occurring hearing or vision loss.

Hearing aids and eyeglasses are provided to the following veterans.³⁵

- Veterans with any compensable service-connected disability.
- Veterans who are former prisoners of war (POWs).
- Veterans who were awarded a Purple Heart.
- Veterans receiving compensation for an injury, or an aggravation of an injury, that occurred as the result of VA treatment.
- Veterans in receipt of an increased pension based on being permanently housebound and in need of regular aid and attendance.
- Veterans with hearing or vision impairment resulting from diseases or the existence of another medical condition for which the veteran is receiving care or services from VA, or which resulted from treatment of that medical condition (e.g., stroke, polytrauma, traumatic brain injury, diabetes, multiple sclerosis, vascular disease, geriatric chronic illnesses, toxicity from drugs, ocular

³² The Department of Veterans Affairs is not the insurer—the entity that underwrites an insurance risk.

³³ Unlike VA health care coverage, veterans and eligible dependents are required to pay monthly premiums for the VADIP.

³⁴ 38 C.F.R. §17.169. For more information, on the VA Dental Insurance Program (VADIP) see <http://www.va.gov/healthbenefits/vadip/>, and http://www.va.gov/healthbenefits/vadip/VADIP_fa_02-18-15.pdf.

³⁵ 38 C.F.R. §17.149, and Department of Veterans Affairs, Prescribing And Providing Eyeglasses, Contact Lenses, and Hearing Aids, VHA Directive 1034(1), April 22, 2014.

- photosensitivity from drugs, cataract surgery, and/or other surgeries performed on the eye, ear, or brain resulting in a vision or hearing impairment).
- Veterans with significant functional or cognitive impairment evidenced by deficiencies in the ability to perform activities of daily living.³⁶
 - Veterans who have hearing and/or vision impairment severe enough that it interferes with their ability to participate actively in their own medical treatment and to reduce the impact of dual sensory impairment (combined hearing and vision loss).

Does the VA Provide Long-Term Care?

The VA provides long-term care services (including residential, home-based, and community-based care) for veterans meeting specified criteria, which may include service-connected conditions and the need for such care.

The Veterans Millennium Healthcare and Benefits Act (P.L. 106-117) requires the VA to provide nursing home services to all enrolled veterans who are 70% or more service-connected disabled, or 60% or more service-connected disabled and unemployable and in need of such care, or who are service-connected for a condition that makes such care necessary.³⁷ The VA meets the requirements of P.L. 106-117 by providing short- and long-term nursing care, respite, and end-of-life care through three different settings: Community Living Centers (CLCs) located on VA medical campuses; contracted care in Community Nursing Homes (CNH); and through the State Veterans Nursing Home (SVNH) program. Under the SVNH program, the VA subsidizes state-operated, long-term care facilities for veterans through a grant and per diem program in states that have petitioned the VA to build and operate a SVNH. The SVNH program primarily provides long-stay, maintenance-level care. Each SVNH is owned and operated by its host state; however, approximately two-thirds of new construction costs and about one-third of per diem costs are provided by the VA. For those veterans who are 70% or more service-connected disabled and reside in a SVNH, the VA provides the full cost of care.

The VA provides a range of non-institutional home and community based services for veterans, which include the following:

- Skilled Home Care—the Purchased Skilled Home Care Program (formerly known as fee basis home care) is a professional home care service that is purchased from private-sector providers by every VA medical center. A VA primary care provider must recommend Skilled Home Care in order for a veteran to receive it. The professional home care services program covers mostly nursing

³⁶ Activities of Daily Living (ADLs) generally refer to activities such as bathing, getting in and out of a bed or chair, eating, dressing, walking across the room, and using the toilet.

³⁷ 38 U.S.C. §1710A. This section is based on Carol J. Sheets and Heather Mahoney-Gleason, “Caregiver Support in the Veterans Health Administration: Caring For Those Who Care,” *GENERATIONS – Journal of the American Society on Aging*, vol. 34, no. 2 (Summer 2010), pp. 92-98.; U.S. Department of Veterans Affairs, Office of Care Coordination, Supporting Veterans’ Caregivers: A Frequently Asked Questions Guide, November 29, 2006, pp. 15-18.; and U.S. Congress, House Committee on Veterans’ Affairs, Subcommittee on Health, *Legislative Hearing on H.R. 1293, H.R. 1197, H.R. 1302, H.R. 1335, H.R. 1546, H.R. 2734, H.R. 2738, H.R. 2770, H.R. 2898 and Draft Discussion Legislation*, 111th Cong., 1st sess., June 18, 2009 (Washington: GPO, 2009), pp. 57-58.

- services, including medical care, social services, occupational therapy, physical therapy, skilled nursing care, and speech and language pathology.
- **Home Based Primary Care**—This program (formerly known as Hospital Based Home Care) began in 1970 and provides medical care to chronically ill or disabled veterans in their own homes through an interdisciplinary treatment team. These services are paid for by the VA and provided by VA personnel.
 - **Veteran-Directed Home & Community Based Care**—The VA partners with federal Area Agencies on Aging to purchase needed services. This program allows the veteran to decide on a case mix of services to best meet care needs and those of the caregiver.
 - **Spinal Cord Injury/Disorders Bowel & Bladder Care**—These programs provide specialized home care services for veterans with spinal cord injuries and related disorders. Services include respite care, long-term care, bowel and bladder care, and caregiver education to veterans.
 - **Homemaker/Home Health Aide**—This program began in 1993 and provides assistance with personal care and related support services for veterans in their own homes through the homemaker/home health aide (H/HHA) benefit. H/HHA services may include assistance with activities of daily living (ADLs), as well as instrumental activities of daily living (IADLs).³⁸ Eligibility for the H/HHA program is based on a clinical judgment by the H/HHA Coordinator and interdisciplinary team that determines if the veteran would, in the absence of H/HHA services, require nursing home equivalent care. The VA pays for these services. H/HHA services are provided by contracted providers. H/HHAs are personnel who are trained and have completed a competency evaluation, and are placed under the general supervision of a nurse.
 - **Community Residential Care (CRC)**³⁹—CRC is a form of enriched housing that provides health care supervision to eligible veterans not in need of hospital or nursing home care, but who, because of medical and psychiatric and/or psychosocial limitations, as determined through a statement of needed care, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. CRCs currently encompass
 - assisted living facilities;
 - personal care homes;
 - family care homes;
 - psychiatric community residential care homes; and
 - medical foster homes.

³⁸ Activities of Daily Living (ADLs) generally refer to activities such as bathing, getting in and out of a bed or chair, eating, dressing, walking across the room, and using the toilet. Instrumental Activities of Daily Living (IADLs) may include activities such as shopping for groceries, light housework, preparing hot meals, using the telephone, taking medications, and managing money.

³⁹ The CRC program is authorized under 38 U.S.C. §1730.

In general, each of the settings listed above must provide room, board, assistance with Activities of Daily Living (ADL), and supervision as determined on an individual basis. The individual veteran makes the final choice of facility, and the cost of residential care is financed by the veteran's own resources. However, placement in residential settings is subject to inspection and approval by the appropriate VA medical center.

Does the VA Pay for Medical Care at Non-VA Facilities?

Under certain circumstances, the VA may reimburse non-VA providers for health care services rendered to VA-enrolled veterans on a fee-for-service basis.

Current law authorizes the VA to provide care outside of the VA health care system under the following circumstances: (1) when a clinical service cannot be provided at a VA medical center (VAMC); (2) when a veteran is unable to access VA health care facilities due to geographic inaccessibility; or (3) in emergencies when delays could lead to life-threatening situations.⁴⁰ Non-VA care may include outpatient care, inpatient care, emergency care, medical transportation, and dental services.⁴¹

What Is the Veterans Choice Program, or Choice Card Program?

The Veterans Choice Program, or Choice Card Program, is a new, temporary program that provides veterans the ability to receive medical care in the community from non-VA providers under certain circumstances.

On August 7, 2014, President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235).⁴² Among other things, the act established a new program (the Veterans Choice Program) that would allow the VA to authorize care for veterans outside the VA health care system if they meet any of the following requirements:

- There is no available medical appointment within 30 days of the veteran's preferred date or the date determined medically necessary by their provider,⁴³
- The veteran resides more than 40 miles from their closest VA medical facility,⁴⁴
or

⁴⁰ VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§1703, 1725, 1728, 8111, and 8153. Also see 38 C.F.R. §17.52 for various categories covered and eligibility for care under 38 U.S.C. §1703. The VA also has authority at 38 U.S.C. §7405(a)(2) to employ providers on a fee basis to provide care in VA-operated facilities.

⁴¹ Department of Veterans Affairs, Veterans Health Administration, *Audit of Non-VA Inpatient Fee Care Program*, Report No: 09-03408-227, Washington, DC, August 18, 2010, p. 1.

⁴² For a section-by-section description of the provisions in the law see, CRS Report R43704, *Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)*, by Sidath Viranga Panangala et al.

⁴³ This means that the VA is unable to identify a particular date, time, location, and entity or health care provider within 30 days of the date that the appointment was deemed clinically necessary by a VA health care provider, or, if no such clinical determination has been made, the date that a veteran prefers to be seen by a health care provider capable of furnishing the hospital care or medical services required by the veteran (Department of Veterans Affairs, "Expanded Access to Non-VA Care Through the Veterans Choice Program," 79 *Federal Register* 65571-65587, November 5, 2014).

- The veteran resides in a state without a full-service VA medical facility that provides hospital care, emergency services, and surgical care and resides more than 20 miles from such a facility (this criterion only applies to veterans residing in three states: Alaska, Hawaii, and New Hampshire).

Generally, to participate in the Veterans Choice Program a veteran must meet one of the following two broad sets of criteria:

- The veteran must be enrolled in the VA health care system as of August 1, 2014, including a veteran enrolled in the VA health care system who has not received hospital care or medical services from the VA and has contacted the VA seeking an initial appointment for the receipt of such care or services; or
- The veteran must be a combat-theater veteran discharged or released from active duty during a five-year period prior to enrollment.

How Is the Veterans Choice Program, or Choice Card Program, Administered?

A private Third Party Administrator (TPA) administers the program on behalf of the VA.

The VA signed contracts with two health care companies—Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation—to help VA administer the Veterans Choice program. The TPA manages, among other things, the Choice Card distribution, call center, veteran counseling, health care provider management, appointment management, reporting, and billing. Health care providers are either part of the TPA network or out of network with TPA but meet requirements of the Choice Act. Generally, the TPA is required to provide a list of approved providers to the veteran to select from. Under the law, the veteran could also request a provider that is not in the TPA's network of providers.

Those veterans who qualify under the 40-mile criteria will generally call the TPA for information or express interest in receiving care outside the VA health care system.⁴⁴ The TPA generally would have received a list of eligible participants from the VA. When an appointment is scheduled for a veteran who qualifies under the 40-mile criteria, the TPA is required to notify the VA medical center (VAMC). Following the veteran's appointment with a non-VA provider, the TPA is required to gather clinical documentation, claim information, and Explanation of Benefit (EOB) information from the provider and submit it to the VA. The VAMC staff is supposed to retrieve documentation from the TPA's web portal and upload the information into the veteran's clinical record. The VA's Chief Business Office Purchased Care (CBOPC) staff is required to then process claim payment to the TPA, and the TPA will make the payment to the non-VA provider.

For those veterans who qualify because they may have to wait more than 30 days for care, authorizations are made based on the Veterans Choice List or Electronic Wait List. The VAMC

(...continued)

⁴⁴ On April 24, 2015, the VA announced that it will determine eligibility for the Veterans Choice Program under the 40-mile rule based on the distance between a veteran's place of residence and the nearest VA medical facility using driving distance rather than straight-line distance or geodesic distance to such a facility (Department of Veterans Affairs, "Driving Distance Eligibility for the Veterans Choice Program," 80 *Federal Register* 22906-22909, April 24, 2015).

⁴⁵ The Veterans Choice Card included the following number for veterans to call: 866-606-8198.

makes the veteran aware of eligibility to participate in the Veterans Choice Program. Generally, for those veterans who have to wait more than 30 days for care, the VAMC submits clinical documentation to the TPA. The veteran will call the TPA for information or express interest in receiving care from a non-VA provider. If the veteran elects to receive care under the Choice Program, the TPA will then schedule an appointment and notify the VAMC of the scheduled appointment. After the scheduled appointment with the non-VA provider, the TPA will follow the same process as described for those who qualify for the 40-mile criteria.

What Is Project ARCH (Access Received Closer to Home)?

Project ARCH is a five-year pilot program to evaluate how to improve access to health care for rural and highly rural veterans by providing these services closer to where they live through contractual agreements with non-VA medical providers.

The Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387) was signed into law on October 10, 2008. Section 403 of this law required VA to conduct pilot programs during a three-year period to provide non-VA health care services through contractual arrangements to eligible veterans. The Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163), signed into law in May 2010, made technical corrections to Section 403 of P.L. 110-387. In February 2011, the VA issued a Request for Proposals (RFP) for interested parties to submit proposals to provide services, and the Project ARCH sites became operational on August 29, 2011. The three-year pilot program was set to expire on August 29, 2014. Section 104 of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146 as amended by P.L. 113-175 and P.L. 113-235)⁴⁶ extended this pilot program by another two years from the date of enactment of P.L. 113-146, and it is now set to expire on August 7, 2016. Furthermore, P.L. 113-146 also stipulated that the Secretary must ensure that medical appointments for those veterans eligible to participate in Project ARCH are scheduled not later than 5 days after the date on which the appointment is requested and occur no later than 30 days after such date.

The Project ARCH pilot provides a range of specified health care services to eligible veterans in Veterans Integrated Service Networks (VISN) 1, 6, 15, 18, and 19. Eligibility for Project ARCH is based on statutory language. Specifically, eligible individuals include veterans who are enrolled in VA for health care services as of the date of the commencement of the pilot program and meet the statutory definition of "covered veterans." Veterans may also participate in the pilot program if they are eligible to enroll under Section 1710(e)(3)(C) of Title 38 of the U.S.C. This includes Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans and veterans who served on active duty in a theater of combat operations or in combat against a hostile force during a period of hostilities after November 11, 1998.

Covered veterans are defined as those veterans residing in a pilot VISN:

- More than 60 minutes away from the nearest VA health care facility providing primary care services,
- More than 120 minutes away from the nearest VA health care facility providing acute hospital care, or

⁴⁶ For a section-by-section description of the provisions in the law, see CRS Report R43704, *Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230; P.L. 113-146)*, by Sidath Viranga Panangala et al.

- More than 240 minutes away from the nearest VA health care facility providing tertiary care.

What Are the Project ARCH Pilot Sites and Services?

Five pilot sites have been established across the country: Caribou, ME; Farmville, VA; Pratt, KS; Flagstaff, AZ; and Billings, MT. Health care services provided include primary care, outpatient specialty care, inpatient acute care, and outpatient diagnostic radiology services, among others. It should be noted that not all services are provided at all pilot sites.

VISN 1: VA New England Healthcare System

- Parent VAMC: VA Maine Healthcare System (Togus)
- Pilot Site: Caribou, ME
- Services Provided:
 - Acute inpatient medical and surgical care, including related consultations and ancillaries.
 - Outpatient specialty consultation, including related diagnostic imaging and laboratory services.

VISN 6: VA Mid-Atlantic Health Care Network

- Parent VAMC: Hunter Holmes McGuire VAMC (Richmond)
- Pilot Site: Farmville, VA
- Services Provided:
 - Primary care, including routine preventive care, diagnostic imaging, and laboratory services.

VISN 15: VA Heartland Network

- Parent VAMC: Robert J. Dole Medical Center (Wichita)
- Pilot Site: Pratt, KS
- Services Provided:
 - Primary care, including routine preventive care, diagnostic imaging, and laboratory services.
 - Behavioral health screening and assessment.

VISN 18: VA Southwest Health Care Network

- Parent VAMC: Northern Arizona VA Health Care System (Prescott)
- Pilot Site: Flagstaff, AZ
- Services Provided:
 - Acute inpatient medical and surgical care, including related consultations and ancillaries.

- Outpatient specialty consultation, including related diagnostic imaging and laboratory services.

VISN 19: Rocky Mountain Network

- Parent VAMC: VA Montana Health Care System (Fort Harrison)
- Pilot Site: Billings, MT
- Services Provided:
 - Acute inpatient medical and surgical care, including related consultations and ancillaries.
 - Outpatient specialty consultation, including related diagnostic imaging and laboratory services.

Does the VA Pay for Emergency Care at Non-VA Facilities?

The VA may pay for emergency care provided to enrolled veterans by non-VA providers based on several factors, such as whether the care is for a service-connected condition.

Generally, to be eligible for non-VA emergency care reimbursement veterans must

- be enrolled in the VA health care system, and
- have received VA medical services within the 24-month period preceding the furnishing of emergency treatment.⁴⁷

Once these general eligibility criteria are met, emergency care reimbursement falls into two categories: (1) payment or reimbursement of emergency care for veterans for a service-connected disability⁴⁸ and (2) payment or reimbursement of emergency care for veterans for a nonservice-connected disability.⁴⁹ The distinct eligibility criteria for each of the two categories are summarized in **Table 2**.

Table 2. VA Reimbursement for Emergency Care

Service-Connected	Nonservice-Connected
The VA is required to pay or reimburse veterans for medical expenses incurred in non-VA facilities when all three of the following conditions apply: ^a	The VA is required to pay or reimburse veterans for medical expenses incurred in non-VA facilities when all four of the following conditions apply:
(1) Delay would have been hazardous to the life or health of the veteran.	(1) Delay would have been hazardous to the life or health of the veteran.
(2) VA or other federal facilities were not feasibly	(2) VA or other federal facilities were not feasibly

⁴⁷ Under current law, “emergency treatment” is defined as medical services furnished, in the judgment of the VA Secretary (1) when VA or other federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable; (2) when such services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health; and (3) until such time as the veteran can be transferred safely to a VA facility (38 U.S.C. §1725(f)(1)).

⁴⁸ 38 U.S.C. §1728.

⁴⁹ 38 U.S.C. §1725.

Service-Connected	Nonservice-Connected
available (or treatment had been refused).	available.
(3) The care was provided for:	(3) The veteran has either:
- a service-connected disability, - a nonservice-connected disability aggravating a service-connected disability, or - any disability of a veteran whose service-connected disability is total and permanent in nature.	- no health coverage (e.g., private health insurance or Medicare) or - coverage that would only partially pay for the emergency treatment.^b
	(4) In cases where the care was provided for a condition caused by an accident or work-related injury, all claims against a third party for payment have been exhausted without success.

Source: CRS Summary of 38 U.S.C. §1728 and 38 U.S.C. §1725.

Notes:

- a. Prior to the enactment of the Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387), the VA was not required to reimburse the non-VA facility for the cost of care after the point of stabilization. P.L. 110-387 mandated that the VA reimburse or pay for the reasonable value of treatment for any veteran who meets above eligibility criteria and defined "emergency treatment" as continuing until the veteran can be transferred safely to a VA or other federal facility, and the VA or other federal facility agrees to accept such a transfer.
- b. Prior to the passage of the Veterans' Emergency Care Fairness Act (P.L. 111-137), a veteran who was enrolled in the VA's health care system was reimbursed for emergency treatment received at a non-VA hospital. However, the statute only permitted such VA reimbursement if the veteran had no other outside health insurance, no matter how limited that other coverage was. P.L. 111-137 would require the VA to pay for emergency treatment for a nonservice-connected condition if a third party is not responsible for paying for the full cost of care. The law also set two limitations on reimbursement as follows: (1) the VA is the secondary payer where a third-party insurer covers a part of the veteran's medical liability (e.g., his or her automobile insurance coverage, private health insurance, or Medicare Part A and Medicare Part B); and (2) the VA is only responsible for the difference between the amount paid by the third-party insurer and the VA allowable amount. Veterans would continue to be responsible for copayments owed to the third-party insurer; if the veteran were responsible for copayments under a private health insurance or Medicare plan, then the veteran would still be liable to pay this (copayment rates and or coinsurance rates are set by the individual insurance policy or Medicare and not the VA). P.L. 111-137 clarifies that veterans are not liable for any remaining balance due to the provider after the third-party insurer and the VA have made their payments.

Costs to Veterans and Insurance Collections

Do Veterans Have to Pay for Their Care?

Whether a veteran is required to pay for VA health care services depends primarily on (1) whether the condition being treated is service-connected, and/or (2) the veteran's enrollment Priority Group.⁵⁰

⁵⁰ The VA classifies veterans into eight enrollment Priority Groups based on an array of factors including (but not limited to) service-connected disabilities or exposures, prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income. The criteria for each Priority Group are summarized in the **Appendix**.

Veterans who are enrolled in the VA health care system do not pay any premiums; however, some veterans are required to pay copayments for medical services and outpatient medications related to the treatment of a nonservice-connected condition.

Table 3 summarizes which Priority Groups are charged copayments for inpatient care, outpatient care, outpatient medication, and long-term care services. Only veterans in Priority Group 1 (those who have been rated 50% or more service-connected) and veterans who are deemed catastrophically disabled by a VA provider are never charged a copayment, even for treatment of a nonservice-connected condition.⁵¹ For veterans in other priority groups, VHA currently has four types of nonservice-connected copayments for which veterans may be charged: outpatient, inpatient, extended care services, and medication. Veterans in all priority groups are not charged copayments for a number of outpatient services, including the following: publicly announced VA health fairs; screenings and immunizations; smoking and weight loss counseling; telephone care; laboratory services; flat film radiology; and electrocardiograms.

For primary care outpatient visits, there is a \$15 copayment charge and for specialty care outpatient visits, a \$50 copayment. Veterans do not receive more than one outpatient copayment charge per day. That is, if the veteran has a primary care visit and a specialty care visit on the same day, the veteran pays only for the specialty care visit. For veterans required to pay an inpatient copayment charge, rates vary based upon whether the veteran is enrolled in Priority Group 7 or not. Veterans enrolled in Priority Group 8 and certain other veterans are responsible for the VA's full inpatient copayment, and veterans enrolled in Priority Group 7 and certain other veterans are responsible for paying 20% of the VA's inpatient copayment. Veterans in Priority Groups 1 through 5 do not have to pay inpatient or outpatient copayments. Veterans in Priority Group 6 may be exempt due to special eligibility for treatment of certain conditions.

For veterans required to pay long-term care copayments, these charges are based on three levels of nonservice-connected care, including inpatient, non-institutional, and adult day health care. Actual copayments vary depending on the veteran's financial situation.

For medication copayments, veterans are not billed if they have a service-connected disability rated 50% or greater, if they are former prisoners of war, or if their medications are related to certain eligibility exceptions. Veterans enrolled in Priority Groups 2 through 6 have a \$960 calendar-year cap on the amount that they can be charged for these copayments.⁵² Veterans who are unable to pay VA's copayment charges may submit requests for assistance, including waivers, hardships, compromises, and repayment plans.⁵³

The VHA bills private health insurers for medical care, supplies, and prescriptions provided to veterans for their nonservice-connected conditions. While the VA cannot bill Medicare, it can bill

⁵¹ The manner in which the VA determines that a veteran is catastrophically disabled is established in regulation. The determinations are based on clinical criteria, rather than (as was formerly the case) medical codes, which change over time. For more information, see U.S. Department of Veterans Affairs, "Criteria for a Catastrophically Disabled Determination for Purposes of Enrollment," 78 *Federal Register* 72576-72579, December 3, 2013.

⁵² U.S. Department of Veterans Affairs, "Copayments for Medications in 2014," 78 *Federal Register* 79315, December 30, 2013.

⁵³ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

Medicare supplemental health insurance carriers for covered services.⁵⁴ Veterans are not responsible for paying any remaining balance of the VA's insurance claim that is not paid or covered by their health insurance carrier. Any payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility.⁵⁵

Table 3. Copayments for Health Care Services (CY2015)

	Inpatient care	Outpatient care	Outpatient medication	Long-term care services
	(\$10/day + \$1,260 for first 90 days and \$630 after 90 days; based on 365-day period)	(\$15 Primary Care; \$50 Specialty Care; \$0 for x-rays, lab, immunizations, etc.)	(\$8 per 30-day supply and a calendar year cap of \$960 for Priority Groups 2-6; \$9 for 30-day supply for Priority Groups 7 and 8) ^a	(Institutional nursing home care units, respite care, geriatric evaluation: \$0-97 per day. Non-institutional respite care, geriatric evaluation, adult day healthcare: \$15 per day. Domiciliary care: \$5 per day)
Priority Group 1	NO	NO	NO	NO
Priority Group 2 ^b	NO	NO	YES	NO
Priority Group 3 ^b	NO	NO	YES	NO
Priority Group 4 ^c	NO	NO	NO	NO
Priority Group 5 ^d	NO	NO	YES	YES
Priority Group 6 ^e	NO	NO	NO	NO
Priority Group 7 ^f	YES	YES	YES	YES
Priority Group 8 ^g	YES	YES	YES	YES

Source: CRS summary based on U.S. Department of Veterans Affairs, "2015 Copayment Rates" (IB 10-430), http://www.va.gov/HEALTHBENEFITS/resources/publications/IB10-430_copay_rates.pdf (dated January 2015).

Notes: "NO" means the veteran is *not* responsible for paying copayments. "YES" means the veteran *may* be liable for partial or full copayments.

- For the period from July 1, 2010, through December 31, 2015, the copayment amount for veterans in Priority Groups 2 through 6 is \$8. There is an annual cap of \$960 per calendar year. When veterans reach the annual cap, they continue to receive medications without making a copayment. For veterans in Priority Groups 7 and 8 the copayment amount from July 1, 2010, through December 31, 2015, is \$9. There is no annual cap for these priority groups.
- No medication copayments if medication is for a service-connected disability. Former POWs are exempt from all medication copayments.
- The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) exempted veterans determined by VA to be catastrophically disabled from inpatient, outpatient and prescription copayments.
- No medication or long-term care copayments if veteran is in receipt of VA pension or has an income below applicable pension threshold.

⁵⁴ 38 U.S.C. §1729.

⁵⁵ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

- e. Priority Group 6 are veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to ionizing radiation; combat veterans within five years of discharge from the military; veterans who participated in Project 112/SHAD; veterans claiming military sexual trauma; Camp Lejeune veterans receiving VA-provided health care for one of the 15 identified illnesses or conditions; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military are subject to copayments when their treatment or medication is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier and are not subject to copayments. However, care provided that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and copayments can apply.
- f. Priority Group 7a and 7c veterans have incomes above the VA Means Test threshold but below the Geographic Means Test threshold and are responsible for 20% of the inpatient copayment and 20% of the inpatient per diem copayment. The Geographic Means Test copayment reduction does not apply to outpatient and medication copayments, and veterans will be assessed the full applicable copayment charges.
- g. Priority Group 8a and 8c veterans have incomes above the VA Means Test threshold and above the Geographic Means Test threshold. Veterans enrolled in these priority groups are responsible for the full inpatient copayment and the inpatient per diem copayment for care of their nonservice-connected conditions. Veterans in these priority groups are also responsible for outpatient and medication copayments for care of their nonservice-connected conditions.

Can the VA Bill Private Health Insurance?

The VA has the authority to bill most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VHA the authority to bill some veterans and most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system to help defray the cost of delivering medical services to veterans.⁵⁶ This law also established means testing for veterans seeking care for nonservice-connected conditions.

Congress authorized the VHA to collect reasonable charges for medical care or services (including the provision of prescription drugs) from a third party to the extent that the veteran or the provider of the care or services would be eligible to receive payment from the third party for (1) a nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract;⁵⁷ (2) a nonservice-connected disability incurred as a result of the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services;⁵⁸ or (3) a nonservice-connected disability incurred as a result of a motor vehicle accident in a state that requires automobile accident reparations (no fault) insurance.⁵⁹ Similarly, the VHA can receive payments from Medicare supplemental coverage plans for nonservice-connected conditions for which the veterans receives care at VHA facilities.

⁵⁶ Veterans' Health-Care and Compensation Rate Amendments of 1985 (P.L. 99-272).

⁵⁷ 38 U.S.C. §1729(a)(2)(D), and 38 C.F.R. §17.101(a)(1)(i).

⁵⁸ 38 U.S.C. §1729(a)(2)(A), and 38 C.F.R. §17.101(a)(1)(ii).

⁵⁹ 38 U.S.C. §1729(a)(2)(B), and 38 C.F.R. §17.101(a)(1)(III).

Veterans are not responsible for paying any remaining balance of the VA's insurance claim not paid or covered by their health insurance. Any payment received by the VA is used to offset "dollar for dollar" a veteran's VA copayment responsibility.⁶⁰

Can the VA Bill Medicare?

The VA is statutorily prohibited from billing Medicare⁶¹ in most situations. Additionally, veterans are responsible for paying all Medicare premiums, deductibles, and co-insurance. The VA has no authority to reimburse Medicare beneficiaries for expenses they incur to obtain medical care under Medicare.⁶²

In general, Medicare is prohibited from reimbursing for any services provided by a federal health care provider unless

- the provider is determined by the Secretary of Health and Human Services (HHS) to be providing services to the public as a community institution or agency;
- the provider is providing services through facilities operated by the Indian Health Service (IHS);⁶³ or
- the services were provided in an emergency (in a hospital setting).

Medicare is also prohibited from making payments to any federal health care provider who is obligated by law or contract to render services at public expense.⁶⁴ Therefore, the VHA is statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans.⁶⁵ Although the legislative history does not indicate congressional intent for this decision, "a safe assumption to be drawn from the exclusion of Medicare [from paying for health care services provided through other federal entities] is that Congress wanted to avoid the unnecessary transfer of federal funds from Medicare to the VA when the money is all coming out of the same coffer."⁶⁶

It should be noted that there is a narrow exception to this statutory prohibition of Medicare reimbursing the VHA. Under current law the VHA can be reimbursed by Medicare (notwithstanding any condition, limitation, or other provision in title XVIII of the Social Security Act) when the VA provides services to Medicare-covered individuals who are not eligible for care under Chapter 17 of Title 38 United States Code (U.S.C.)⁶⁷ and who are afforded VA care or

⁶⁰ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs*, 111th Cong., 1st sess., October 15, 2009 (Washington: GPO, 2010), p. 43.

⁶¹ "Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries." CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

⁶² 42 U.S.C. §1395y(a)(3)).

⁶³ In 1976, Congress authorized Medicare and Medicaid payments for services delivered in Indian health facilities (whether operated by the IHS or Tribes) through amendments to the Social Security Act made in the Indian Health Care Improvement Act of 1976 (P.L. 94-437) (IHICIA). This was permanently authorized by the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148).

⁶⁴ 42 U.S.C. §§1395f(c), 1395n(d), 1395f(a).

⁶⁵ 42 U.S.C. §1395f(c), and 38 U.S.C. §1729(i)(1)(B)(i).

⁶⁶ *United States v. Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718, 727 n. 5 (4th Cir.).

⁶⁷ Chapter 17 of Title 38 U.S.C. details the eligibility criteria as well as programs relating to the provision of medical (continued...)

services under a “sharing” agreement.⁶⁸ Medicare can reimburse veterans for VA copayment amounts charged for VA authorized services provided by non-VA sources (or provide credit toward their Medicare deductible or coinsurance amounts).⁶⁹ Medicare may also pay for (Medicare covered) services for which the VA does not make any payment. “For example, if a veteran is authorized ‘fee basis’ care at VA expense for a service-connected back injury, and receives treatment for a different condition for which the VA does not pay, Medicare can pay for the (covered) services that are not reimbursable by the VA.”⁷⁰

(...continued)

care, and nursing home care, among other things, for veterans and their eligible dependents.

⁶⁸ 38 U.S.C. §8153(d). A sharing agreement is a written contract that allows VHA to buy, sell, or exchange health care resources and services with non-VA facilities. VHA could enter into noncompetitive sharing agreements with affiliated institutions (such as affiliated medical schools—affiliated with VHA under 38 U.S.C. §7302) and other entities associated with these affiliated institutions (such as university hospitals).

⁶⁹ Medicare Benefit Policy Manual, Chapter 16—General Exclusions from Coverage, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf>.

⁷⁰ Ibid. Fee basis care is care purchased by the VA from non-VA/community providers, as compared to VA care that is delivered by VA providers in VA-owned and VA-operated sites of care.

Appendix. VA Priority Groups and Their Eligibility Criteria

The VA classifies veterans into eight enrollment Priority Groups based on an array of factors including (but not limited to) service-connected disabilities or exposures,⁷¹ prisoner of war (POW) status, receipt of a Purple Heart or Medal of Honor, and income. The criteria for each Priority Group are summarized in **Table A-1**.

The eight Priority Groups fall into two broad categories. The first group is composed of veterans with service-connected disabilities or with incomes below an established means test. These veterans are regarded by the VA as “high priority” veterans, and they are enrolled in Priority Groups 1-6. Veterans enrolled in Priority Groups 1-6 include the following:

- veterans in need of care for a service-connected disability;
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the Purple Heart;
- veterans who have been determined by the VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have an annual income and net worth below a VA-established means test threshold.

The VA looks at applicants’ gross household income (earned and unearned) and deductible medical expenses for the previous year to determine their specific priority categories and whether they have to pay copayments for nonservice-connected care.⁷² In addition, veterans are asked to provide the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The VA may bill these payers for treatment of conditions that are *not* a result of injuries or illnesses incurred or aggravated during military service.

The second group of veterans is composed of those who do not fall into one of the first six priority groups—primarily veterans with nonservice-connected medical conditions and with

⁷¹ For example, veterans who may have been exposed to Agent Orange during the Vietnam War or veterans who may have diseases potentially related to service in the Gulf War may be eligible to receive care.

⁷² To align the VA’s health care program with other federal health care programs’ financial assessment requirements, effective January 1, 2015, the VA stopped collecting veterans’ net worth information for purposes of financial assessment for health benefits.

incomes above the VA-established means test threshold. These veterans are enrolled in Priority Groups 7 or 8.⁷³

Table A-2 provides information on income thresholds for VA health care benefits.

Table A-1. VA Priority Groups and Their Eligibility Criteria

Priority Group 1

Veterans with service-connected disabilities rated 50% or more disabling

Veterans determined by VA to be unemployable due to service-connected conditions

Priority Group 2

Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

Veterans who are former POWs^a

Veterans awarded the Purple Heart^b

Veterans in receipt of the Medal of Honor^c

Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty

Veterans with service-connected disabilities rated 10% or 20% disabling

Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”

Priority Group 4

Veterans who are receiving aid and attendance or housebound benefits

Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose previous year’s gross household income (earned and unearned income) is below the established VA means test thresholds^d

Veterans receiving VA pension benefits

Veterans eligible for Medicaid benefits

Priority Group 6

Compensable 0% service-connected veterans

Mexican Border War veterans

Veterans solely seeking care for disorders associated with:

- exposure to herbicides while serving in Vietnam between January 9, 1962, and May 7, 1975; or
- ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
- Project 112/SHAD participants; or

⁷³ The VA considers a veteran’s gross household income (both earned and unearned income, as well as his/her spouse’s and dependent children’s income) for the previous year. Earned income is usually wages received from working. Unearned income includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and earnings from other assets. The number of persons in the veterans’ family will be factored into the calculation to determine the applicable income threshold. 38 C.F.R. §17.36(b)(7) (2009).

—for disorders associated with service in the Gulf War and who served between August 2, 1990, and November 11, 1998; or

—for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as follows:

—Veterans discharged from active duty before January 27, 2003 and did not enroll on or before such date, for a three-year period beginning on January 27, 2008;

—Veterans discharged from the active duty after January 27, 2003, for a five-year period beginning on the date of such discharge or release; or

—Veterans discharged from active duty after January 1, 2009, and before January 1, 2011, but did not enroll during the five-year period of post discharge eligibility there is a one-year period beginning on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act (February 12, 2015)^e

Veterans who served on active duty at Camp Lejeune in North Carolina for not less than 30 days during the period beginning on August 1, 1953, and ending on December 31, 1987, for any of the 15 medical conditions specified in 38 U.S.C. 1710(e)(1)(F).^f

Priority Group 7

Veterans who agree to pay specified copayments with income above the VA means test threshold and income below the VA national geographic income thresholds

Priority Group 8

Veterans who agree to pay specified copayments with income above the VA means test threshold and the VA national geographic threshold

Subpriority a: Noncompensable 0% service-connected and enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status

Subpriority b: Noncompensable 0% service-connected and enrolled on or after June 15, 2009, whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less

Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status

Subpriority d: Nonservice-connected veterans enrolled on or after June 15, 2009, whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less

Subpriority e: Noncompensable 0% service-connected veterans not meeting the above criteria (**currently not eligible for enrollment**)

Subpriority g: Nonservice-connected veterans not meeting the above criteria (**currently not eligible for enrollment**)

Source: Department of Veterans Affairs.

Notes: Service-connected disability means, with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service.

- a. Veterans who are former prisoners of war (POWs) are placed in Priority Group 3. This change occurred with the enactment of the Former Prisoner of War Benefits Act of 1981 (P.L. 97-37) on August 14, 1981.
- b. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on November 30, 1999.
- c. Veterans in receipt of the Medal of Honor are in Priority Group 3. This change occurred with the enactment of the Caregiver and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) on May 5, 2010.
- d. To align VA's health care program with other federal health care programs' financial assessment requirements, effective January 1, 2015, VA stopped collecting veterans' net worth information for purposes of financial assessment for health benefits.
- e. These changes were made by the Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2).

- f. Veterans who served on active duty at Camp Lejeune in North Carolina between August 1, 1953, and December 31, 1987, are placed in Priority Group 6. These veterans are eligible to receive free medical care for the following 15 illnesses or conditions: esophageal cancer; lung cancer; breast cancer; bladder cancer; kidney cancer; leukemia; multiple myeloma; myelodysplastic syndromes; renal toxicity; hepatic steatosis; female infertility; miscarriage; scleroderma; neurobehavioral effects; and non-Hodgkin's lymphoma. This change originally occurred with the enactment of the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) on August 6, 2012. The previous time period of January 1, 1957, through December 31, 1987, contained in P.L. 112-154 was then amended by the Consolidated and Further Continuing Appropriations Act, 2015 (H.R. 83; P.L. 113-235).

Table A-2. National Income Thresholds for CY2015

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes of—	Free VA prescriptions and travel benefits for veterans with Aid and Attendance incomes of—	Free VA prescriptions and travel benefits for veterans with Housebound Benefit incomes of—	Free VA Health Care for veterans with incomes of—	Enrollment in Priority Group 8 for veterans with incomes of—
No dependents	\$12,868 or less	\$21,466 or less	\$15,725 or less	\$31,978 or less	\$35,176 or less
1 dependent	\$16,851 or less	\$25,488 or less	\$19,710 or less	\$38,374 or less	\$42,211 or less
2 dependents	\$19,049 or less	\$27,646 or less	\$21,908 or less	\$40,572 or less	\$44,629 or less
3 dependents	\$21,247 or less	\$29,844 or less	\$24,106 or less	\$42,770 or less	\$47,047 or less
4 dependents	\$23,445 or less	\$32,042 or less	\$26,304 or less	\$44,968 or less	\$49,465 or less
For each additional dependent above two dependents, add:	\$2,198	\$2,198	\$2,198	\$2,198	\$2,198

Source: Department of Veterans Affairs.

Notes: For geographic variations, see <http://nationalincomelimits.vaftl.us/>.

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